



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICARE AT OAKMONT
7200 OAKMONT BLVD
FORT WORTH TX 76132

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-12-0624-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I explained to them that each procedure performed was performed through separate sessions. Each procedure was performed in separate rooms by two different physicians and with different equipment. The block given was to control post operative pain." "Based on our review of the NCCI edit list, the verve [sic] block coded 64415 is reimbursable because it was given by a different doctor that performed the procedure."

Amount in Dispute: \$343.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In addition to the nerve block, the claimant also underwent an excision of the distal clavicle on the same date of service. The carrier has paid for the partial claviculectomy performed at the same facility (the requestor is the facility). The carrier maintains that no reimbursement is due for the nerve block because the procedure cannot be billed separately when performed in conjunction with the claviculectomy on the same date of service. Billing separately constitutes unbundling, and this is not appropriate per the National Correct Coding initiative."

Response Submitted by: Flahive, Ogden & Latson, P.O. Box 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2011	ASC Services for Code 64415-SG-RT	\$343.85	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits dated May 19, 2011
 - CCI Comprehensive Component Procedure.
 - 236-This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding initiative.

Issues

1. Is CPT code 64415-SG-RT a component of another procedure performed on the disputed date?
Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for CPT code 64415-SG-RT based upon reason code "236-This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding initiative".
CPT code 64415 is defined as "Injection, anesthetic agent; brachial plexus, single".
On the disputed date of service the requestor billed CPT code 23120-SG-RT and 64415-SG-RT.
Per NCCI edits, CPT code 64415 is a component of 23120; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

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Signature	Medical Fee Dispute Resolution Officer	Date

5/23/2012

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.